Authorization for Use and Disclosure of Protected Health Information in online Therapeutic Conversations

Client's name:_____
First Middle Last

Date of birth: _ _/_ _/_ _ _ _

Authorization for teleMental health services by Anne Minor, LCSW.

I _____, authorize Anne Minor, LCSW, to engage in therapeutic conversation with me via Skype at the following Skype address _____.

The purpose of this authorization is to enable Anne Minor, LCSW to engage in an online therapy format. While Skype use AES encryption, teleMental health can present some confidentiality concerns not present in traditional face to face counseling. The limits to this authorization are:
_____

_____.

This authorization is voluntary and use of my name as protected health information must conform to applicable law and limits described herein.

I understand that I can rescind this authorization for release at any time by notifying the requester in writing.

The original document is to be held in my confidential file and I have received a copy of this two page document describing my rights in relation to this authorization.

Client's signature:_____
name date